CapSpecialty®
Capitol Specialty Insurance Corporation
A Stock Company
P. O. Box 5900
Madison, WI 53705-0900

Miscellaneous Medical General Application

NOTE: NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED OR THAT ANY ITEMS REFERENCED IN QUESTIONS OR ANSWERS TO QUESTIONS WILL BE COVERED EVEN IF COVERAGE IS OFFERED AND BOUND. SOME RESPONSES MAY REQUIRE MORE SPACE THAN THAT PROVIDED IN THE APPLICATION ITSELF. PLEASE PROVIDE THOSE RESPONSES ON A SEPARATE PAGE AND ATTACH IT TO THIS APPLICATION.

I. APPLICANT INFORMATION

1.1	Proposed **First Named Insured** (This is how the name & address of the Insured will read on the Declarations Page if coverage is Bound.):	
	Name:	
	Address:	
	City, State, Zip:	
	County:	
	Phone:	
1.2	Website Address(es):	
1.3	Date Established:	
1.4	Is Applicant a:	☐ sole-proprietor ☐ partnership ☐ LLC ☐ corporation ☐ joint-venture ☐ non-profit ☐ individual ☐ other, describe: _____

FOR THE REMAINDER OF THIS APPLICATION, "*APPLICANT*" REFERS INDIVIDUALLY AND COLLECTIVELY TO THE ENTITY(IES) FOR WHICH COVERAGE IS DESIRED, AS WELL AS EACH PERSON WHO IS AN OFFICER, DIRECTOR, OWNER, PARTNER OR EMPLOYEE OF THESE ENTITY(IES).

1.5	Please provide the total number of Applicant's employees:	
1.6	Does Applicant have any subsidiaries?	☐ Yes ☐ No
	If yes, please provide details.	
1.7	Within the past five years, has Applicant changed its name, acquired any business or merged or consolidated with any other entity?	☐ Yes ☐ No
	If yes, please provide details.	

II. REVENUE INFORMATION

2.1 Please provide the following information regarding Applicant's operations:

Fiscal Year End Date: _____ (mm/dd/yyyy)	**Past Fiscal Year**		**Current Fiscal Year**		**Next Projected Fiscal Year**	
Total Gross Revenue or Budget:	US:	$	US:	$	US:	$
	Foreign:	$	Foreign:	$	Foreign:	$
	Total:	$	Total:	$	Total:	$

III. SERVICES

3.1	Describe the overall operations and services provided:
3.2	Please complete appropriate supplement in accordance with your type of organization.

IV. CURRENT / PRIOR COVERAGE

4.1 Prior Professional Liability Insurance:

Policy Period	Carrier	Limits	Deductible	Premium	Claims-Made or Occurrence

4.2	What is the retroactive date of the current policy?					
4.3	Has Applicant ever applied for Professional Liability coverage and been denied, cancelled or non-renewed?				☐ Yes	☐ No
4.4	Does Applicant maintain General Liability coverage?				☐ Yes	☐ No
	Carrier:		**Limits:**	**Expiration Date:**		

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V. DESIRED LIMITS / DEDUCTIBLE OPTION(S)

5.1	Desired Limits:	
	Each Claim:	☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000 ☐ Other _____
	Aggregate Limit	☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000 ☐ Other _____
5.2	Desired Deductible:	☐ $0 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other _____

VI. HISTORY

6.1	Is Applicant aware of any actual or alleged fact, circumstance, situation, error or omission, which can reasonably be expected to result in a Claim, suit or proceeding being made against Applicant?	☐ Yes ☐ No
6.2	Has Applicant or any of Applicant's predecessors in business, affiliates, or past or present: partners, owners, officers, sales persons or employees been investigated and/or cited by any regulatory agency, certifying body, or other governmental entity?	☐ Yes ☐ No

The policy for which Applicant is applying, if issued, will not insure any Claims made against the Applicant prior to the Inception Date of the policy or any subsequent claims, suits or proceedings arising there-from.

6.3	If any of the answers to questions 6.1 or 6.2 above are "Yes", have all matters been reported to appropriate insurance carriers?	☐ Yes ☐ No

VII. REPRESENTATIONS

This Application must be signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application. By signing this Application, Applicant represents and warrants the following:	
1.	***The statements in the Application or Renewal Application furnished to the Company are accurate and complete;***
2.	***Those statements furnished to the Company are representations Applicant makes on behalf of all proposed Insureds;***
3.	***Those representations are a material inducement to the Company to provide a premium proposal;***
4.	***If a policy is issued, the Company will have issued this Policy in reliance upon those representations;***
5.	***If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and***
6.	***The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.***

As used herein, the "Company" shall be Capitol Indemnity Corporation or Capitol Specialty Insurance Corporation.

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_____ _____

Signature of authorized representative of Applicant **Title**

_____ _____

Type / Print name of authorized representative **Date**

_____

E-mail address of authorized representative

VIII. FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

(Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA and WV).

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

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APPLICABLE IN CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN FL AND OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL only.

APPLICABLE IN KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KY, NY, OH AND PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

APPLICABLE IN ME, TN, VA AND WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

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Laboratory Facilities Supplemental Application

I. APPLICANT INFORMATION

1.1	Applicant Name:	
1.2	Website(s):	

II. CRITICAL UNDERWRITING QUESTIONS

2.1	Do you provide any other medical services besides laboratory services?	☐ Yes ☐ No
	If yes, please provide details:	
2.2	Do you have a formalized employee verification program including background checks?	☐ Yes ☐ No
2.3	Do you maintain a current license in accordance with applicable state and federal regulations?	☐ Yes ☐ No
2.4	Do you have any employed pathologists who interpret and provide results to patients?	☐ Yes ☐ No
	If yes, are they required to carry separate Professional insurance?	☐ Yes ☐ No
2.5	Does the Applicant re-screen 100% of negative Pap Smears?	☐ Yes ☐ No
2.6	Do you outsource more than 50% of your work to another facility?	☐ Yes ☐ No
2.7	During the past five (5) years, has any claim that is within the scope of the proposed insurance been made against the applicant or against any entity or individual whom this proposed insurance is for?	☐ Yes ☐ No

If answer to 2.7 is yes, please provide loss runs from the previous carrier.

III. RATING INFORMATION FOR MEDICAL PROFESSIONALS

The following information affects our pricing model and is critical for an accurate assessment of your exposure.

3.1 Please state the types of services you are providing by annual gross receipts for the next projected policy period and the current one:

Type of Service / Testing	Annual Gross Receipts	
	Projected Policy Period	Current Policy Period
Anatomical Pathology (Cytology, Histology, Pathology etc.):		
Clinical Pathology (ART, Blood Bank, Endocrinology, Hematology, Immunology, Microbiology, Parasitology, Sperm Bank, Toxicology, or Virology, etc.)		
Forensic / Genetic / Paternity:		
Pap Smear:		
Research:		
Other, describe: _____		

3.2	Please provide any past or current accreditations for your organization:	
	☐ CAP ☐ CLIA ☐ SAMSHA ☐ Other: _____	
3.3	If you are a member of either a state or national organization, please provide the name:	
3.4	Is the applicant or any entity aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be assumed to give rise to a claim that may fall within the scope of the proposed insurance?	☐ Yes ☐ No
	If yes, please provide details in writing to us.	

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Laboratory Facilities Supplemental Application

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Signature of authorized representative of Applicant	**Title**
Type / Print name of authorized representative	**Date**
Producer Signature	**Date**